CCA-1021AFORNA (9-02)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

UNPAID COPAYMENT WORKSHEET

TO:

CHILD CARE SPECIALIST'S NAME	FAX NO. ( )
ADDRESS *(No., Street, City, State, ZIP)*	

FROM:

PROVIDER'S NAME	PROVIDER ID NO.
PROVIDER'S CONTACT PERSON'S NAME	PHONE NO. ( )
PARENT/RESPONSIBLE PERSON'S NAME	ID NO.
CHILD(REN)'S NAME(S)	

I have attempted to collect copayment fees and have not received the total amount owed for the time period of _____ *(Date)* to _____ *(Date)* .

For this period of time, I estimate that the total amount of additional charges is $ _____ and the amount of copayment is $ _____ .

I have made the following attempt(s) to collect the outstanding copayment amount:
☐ Oral ☐ Written ☐ Small Claims Court ☐ Other:

I understand that any payment made by the parent or responsible person will first be applied to the outstanding copayment balance.

PROVIDER'S CONTACT PERSON'S SIGNATURE	DATE

COPAYMENT: A fixed daily fee that the DES assigns to families based on the eligible family's size and income. The copayment is not to be considered the difference (dollar amount) between the amount that DES reimburses the provider and the provider's actual charges.

ADDITIONAL CHARGES: Any fee charged by a provider that exceeds the DES reimbursement rate, minus any DES-established copayment, is considered an additional charge. This is the daily amount of the provider rate not subsidized by DES, and is the responsibility of the parent/guardian to reimburse the provider. Additional charges are not to be referred to as copayments.

FOR DES USE ONLY BELOW THIS LINE

PARENT OR RESPONSIBLE PERSON'S NAME *(Last, First)*

1. 1ST CHILD'S NAME	ID NO.	1A. TOTAL AMOUNT OF COPAYMENT OWED FOR CHILD 1: $
2. 2ND CHILD'S NAME	ID NO.	2A. TOTAL AMOUNT OF COPAYMENT OWED FOR CHILD 2: $
3. 3RD CHILD'S NAME	ID NO.	3A. TOTAL AMOUNT OF COPAYMENT OWED FOR CHILD 3: $

4. TOTAL COPAYMENT AMOUNT OWED *(Add 1A, 2A, and 3A)* $

5. TOTAL AMOUNT PAID BY PARENT OR RESPONSIBLE PERSON DURING THE ABOVE-STATED TIME PERIOD $

6. COPAYMENT AMOUNT OWED BY PARENT OR RESPONSIBLE PERSON *(If the amount entered on line 4 is greater than the amount on line 5, subtract line 5 from line 4 and enter the remainder here)* $

7. NO COPAYMENT OWED BY PARENT OR RESPONSIBLE PERSON *(If the amount on line 5 is equal to or greater than the amount on line 4, enter 0 here)* $

1. PROVIDER'S CONTACT PERSON'S NAME	DATE PROVIDER CONTACTED

2. COPAYMENT STATUS ☐ Resolved ☐ Unresolved *(If unresolved complete 3 below)*

3. DATE 30-DAY NOTICE OF ACTION (CC-502) SENT TO CLIENT (*Complete 4 and 5 by 30th day)*

4. PROVIDER'S CONTACT PERSON'S NAME		DATE PROVIDER CONTACTED
5. COPAYMENT STATUS ☐ Paid in Full ☐ Satisfactory Arrangements Made ☐ Case Closed		DATE
VERIFIED BY	TITLE	DATE

Equal Opportunity Employer/Program
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